MEDICAL RISKS OF CIA PERSONNEL

Employment by the Central Intelligence Agency carries with it extraordinary health risks. These risks are inherent in both geographic and socio-political environments to which employees are assigned. Our personnel are asked to live and work in locales plagued by serious infectious diseases rarely if ever seen in the United States. They must expose themselves to high risk modes of transportation, and undertake assignments under politically and militarily unstable circumstances. Inevitably these employees contract diseases and sustain injuries, sometimes fatally almost never encountered by Americans of comparable socio-economic background.

For many of the same geographic and socio-political reasons, the medical resources available locally to deal with these problems are almost uniformly inadequate, if present at all. As a result, even "routine" medical problems often take on grave overtones; those which begin as serious problems are unusually likely to prove fatal. While the Agency attempts to deal with this problem by allowing only the healthiest of its employees to undertake most overseas assignments and by providing consultative coverage by a regionally assigned physician, this falls far short of recreating the healthful medical context left behind in the United States. As a result large numbers of employees or their families must be returned to the United States each year in order to receive adequate medical care. Even this heroic effort does not avoid an excessive degree of death or permanent impairment attributable solely to the nature of the assignment accepted.

In addition to these purely clinical hazards, which also impact on employees indirectly through their families illnesses, Agency personnel are confronted with psychological stresses which over the long haul extract a health toll just as great. In addition to the subtle factors of cultural translocation, and family disruption, there are not infrequently highly traumatic stress events. Scores of employees have been imprisoned, sometimes for years, or otherwise harassed when their Agency affiliation has become known. In the extreme case, one official was assassinated. Much more commonly employees and their families confront the more diffuse crises associated with civil disorder, terrorism, and exceptionally high local crime rates.

No person of comparable social background is subjected to even remotely comparable factors in the American suburban setting in which our employees otherwise would have remained. Not suprisingly, therefore, despite the clinical risks of Agency assignment abroad and the extensive screening of assignees, psychiatric problems are the leading cause of employees casualties overseas. They alone account for about 40% of all permanent employee early returns from overseas assignments; among employee dependent wives permantly returned, this figure rises to nearly 60%.

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Through its provisions the CIARDS program currently recognizes and partially compensates employees for the toll extracted by Agency employment. By facilitating the retirement of employees in their fifties, it also recognizes that many assignments can only be undertaken successfully by healthy, relatively young employees. Where circumstances have forced the assignment of even carefully screened older employees, the medical casualty rate has gone up in direct proportion. In short, were the current provisions of CIARDS to be terminated, not only would there be no adequate compensation for the risks associated with Agency employment, there also would be no satisfactory way to deal with the large number of older employees medically unqualified for many of our assignments.

The Frank Health Hazards

Employees of the Central Intelligence Agency, unlike those who work and reside within the safe and sanitary confines of the United States, are regularly exposed to both hostile and dangerous environments. Despite an Agency selection process and support system designed to minimize medical casualties, these work-related hazards take a high toll among our employees.

To date the requirement that employees work in paramilitary settings, or areas of marked civil unrest has led directly to the deaths--by bombs, mines, grenades, artillery, or gunshot wounds--of eleven employees. Moreover, during the decade from 1967 to 1976 alone an additional 30 employees were injured--some gravely (e.g., blinded)--directly through enemy action. Beyond these casualties, an additonal 24 employees have died in job-related air fatalities, of which a third were in paramilitary environments or known to be caused by weapons fire. Because of the circumstances in which Agency employees are called upon to fly, the overall air fatality death rate (from 1950-1979) among Agency employees (including those assigned solely to domestic duties) is approximately 5-10 times the national average. Those assigned overseas (i.e., CIARDS candidates) have a fatality rate 15-20 times the national average. The requirements of the 1960's--which surely will be repeated again--led to an overseas air fatality rate for that decade about 30 times higher than seen in the United States.

Though more dramatic, job-related trauma casualties do not really match in numbers the toll taken worldwide by the unusual diseases to which employees are exposed--diseases either altogether eradicated from the United States or very rare among adults of backgrounds comparable to our personnel. Despite a highly selective screening process, vigorous immunization and preventive medicine program, and extensive clinical field support, Agency employees over the years have contracted and occasionally died from these diseases. This is not just an old problem limited to the polio deaths among employees in the Far East in the 1950's. The most recent fatality of this sort was due to fulminant hepatitis B and took place within the recent past.

Because medical records in the past were not designed to accommodate retrospective studies, it is not always possible to reconstruct comparative casualty rates for various diseases. Those calculations which are possible clearly illustrate, but fall far short of fully describing, the general hazards involved. The incidence of hepatitis and of tuberculosis among Agency employees, which should be substantially below the national average because of their socio-economic background, rises to 3 to 4 times the national average with assignments abroad. Malaria, a disease almost never seen in the U.S., struck 26 Agency employees during the 1970's alone, which equates in our small group to a rate hundreds of time the national average (at least 400 times). Were data more complete, comparable statements could be made about many exotic diseases, such as typhoid fever, amoebiasis and amoebic abscess, and a whole host of other parasitic infestations.

The one area where our selection process can lower the probability of casualties to (or below) the national norm is in the realm of chronic diseases. By carefully screening out those known to be at increased risk for such things as cardio-vascular, enocrine, or gastro-intestinal disorders, or spreading malignancies, we spare both the individual and the government the potential catastrophe of experiencing such things overseas. Therefore the rates for deaths related to these disorders are low. Even here, however, we still run an unusually high risk of one form of cancer. Apparently because so many of our fair-skinned employees are assigned to tropical or sub-tropical posts, our death rate from sun-induced melanomas eventually reaches (at retirement) a level seven times the national norm.

The Medical Resource Risks

A risk of potentially greater importance than that of the frank health hazards abroad is found in the total inadequacy of local medical resources to deal with medical emergencies. This is the principal concern which lies behind the extensive screening program undertaken by the Office of Medical Services. People with predictably high risks for developing a serious or complicated problem can almost never be assured of an adequate medical response in the vast majority of posts to which Agency employees are assigned. The solution to this is seen in not sending high risk people overseas, and in providing regional consultative service for those who are healthy enough to go. Even so, hundreds of employees have been returned to the United States during the last fifteen years solely for the purpose of obtaining competent medical evaluation. If dependent medical evaluations are included, the number is well over a thousand. While there have been improvements in medical care overseas in recent years, these have been far outstripped by progress in the United States. On balance, the relative standard of care encountered overseas has fallen even further behind with the total requirement for evaluations therefore rising sharply.

The medevac solution is successful only when the medical problem can wait. However, even under the best of circumstances, it often is impossible to obtain expertise at the time it is most needed during a medical crisis abroad. This is well illustrated by the fatality rate seen among Agency employees who suffer heart attacks abroad. Preliminary analysis suggests that these rates are 2 to 3 times higher than in the United States. While a large majority of those suffering heart attacks in the United States survive the first month following their attack, most Agency employees abroad who suffer heart attacks do not survive. Recently, for example, a forty year old employee suffered what apparently was a heart attack in a European post (a region far more sophisticated than any other division to which our people are assigned). The ambulance service took an hour to respond to his wife's call for help, and he was pronounced dead twenty minutes after arrival at the hospital. While we cannot be sure what actually happened, in suburban Washington, D.C., the response would have taken only minutes. More importantly competent Emergency Medical Technicians, equipped with advanced cardiac life support treatment capability and telemetry to local hospitals, would probably have been able to resuscitate this type of case. Such a sophisticated response is totally out of the question at almost any of our posts. Indeed, so far as this type of problem is concerned many of the local hospitals abroad are not as well equipped or staffed as even our modern ambulances in the United States. There is no log of such cases, but they unquestionably occur every year.

Short of sending thousands of doctors into the field, we can only hope to reduce the likelihood of a serious crisis by careful screening and rigorous criteria of assignability, and careful overseas monitoring. This does not minimize the risks accepted by those employees who are assigned to such posts. As the record clearly demonstrates, medicine has not reached the point where we can assure that only those who are immune from these problems will be sent overseas. Over 40 employees have died from heart attacks abroad. Three-fourths of these have been in the last 15 years alone, from a total of about 50 heart attacks during these years. (In the United States, a comparable number of attacks could be expected to lead to 10 to 15 deaths, rather than the 30 or so the Agency experienced.) Similar observations are possible regarding cancer as well as neurological and endocrine problems, but the point is the same. Even healthy employees pay a price in the medical care that is available when they are sent abroad.

The Substantial Additional Risks

Although one is inclined to think of the hazards abroad in terms of infectious disease, inadequate medical care and paramilitary dangers, in practice it is the more subtle risks of overseas living which extract the greatest toll on our employees. To begin with, most employees have dependents with them, dependents who are subjected to the same medically hostile environment with all its

attendant problems, more medical evacuation cases, of almost any category selected, are present in the dependent population than among the employees. The problem of overseas stress, however, goes much further.

Beyond the intangible burden imposed on employees and their families from cultural translocation, or serious deficiencies in the non-medical resources available (e.g., in schooling or recreational outlets), the modern climate abroad has some more readily quantifiable problems. One of the most apparent, in recent years, is terrorism. While this is subjectively apparent to all, it is easy, from the perspective of suburban Washington, to overlook the ubiquity and absolute magnitude of the problem. Between 1968 and 1982 there were nearly 8000 terrorist incidents worldwide, 3500 of which were targetted against Americans. In one of these an Agency official was assassinated because of his Agency affiliation. Almost no country--and therefore virtually none of our posts--has been immune from such incidents. During these years terrorists attacks on foreign diplomats have taken place in 123 different countries. Nor is the overall incidence of the attacks on Americans declining. In 1982 alone there were 400 such attacks. While such episodes rarely add any "emotional" burden to the rigors of American suburban life, this is distinctly not the case for those who go and take their families, abroad on official assignments.

Although terrorist activity, because of its frequency and apparent unpredictability, imposes a fairly wide-ranging strain on those living abroad, even it cannot compare to the less frequent episodes in which Agency employees are taken prisoner, or when the civil structure or political context disintegrates to such a point that an emergency evacuation of all employees or dependents is suddenly necessary. Given the environments in which Agency employees have been asked to serve over the years, this has not been a rare occurrence. Although no complete log is available in OMS, a dozen or more Agency employees are known to us who have been imprisoned, sometimes for many years, because of their Agency employment. And emergency evacuations have involved hundreds of

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All of these political, civil, and terrorist disruptions, important though they are to the emotional climate abroad, probably

is not equal in day-to-day impact to the extraordinary level of time to which our people are exposed. It is the very real danger of mugging, or robbery, or breaking and entry that dominates much of the conversation of both employees and dependents when they try to describe problems in their overseas communities. While there are no systematic records of these episodes, their frequency greatly exceeds anything to be found in American suburbia. Again, just within the last month, two muggings cases were reported to OMS--but we heard about these only because physical injuries were sustained. (over just the past year crime-related injuries have ranged from lacerations and abrasions to joint dislocations to an abdominal stab wound.) Most cases are not reported at all, or only informally, even when--as in one case--an individual or his family reportedly had been victimized many times during a two year tour. Consider, for example, the impact on an American suburbanite, of the following episode, also within the recent past. Noise was heard outside, and a group brandishing machetes were discovered attempting to pry open the sliding patio doors. The telephone lines had been cut. Eventually the group gave up its efforts, so "no" losses were sustained. Were it possible to do actual rate calculations on such crimes, employees abroad certainly would have an incidence a hundred times those living in the suburbs of Washington, D.C.

The Psychological Toll

In view of the litany of "subtle" risks outlined above, it should come as no surprise that despite an extraordinarily detailed psychiatric screening program, both at the time of first employment and prior to overseas assignments, psychiatric diagnoses alone account for nearly 40% of all employee casualties abroad, and for nearly 60% of dependent early returns. This consistently has been the case as far back as our analysis can be extended. Overall, well over 100 Agency employees have been returned permanently from overseas assignments during the past 15 years for psychiatric reasons. Additionally, more than 100 more have been returned because of psychiatric problems in their dependents. There is also a grim predictability to the fact that employees of the Operations Directorate, comprising only about a third of the Agency population over the years, has accounted for 60% of employee suicides, and that the Administration Directorate accounts for three-fourths of the remaining 40%. These are the Directorates whose employees make up virtually all of our overseas staff.

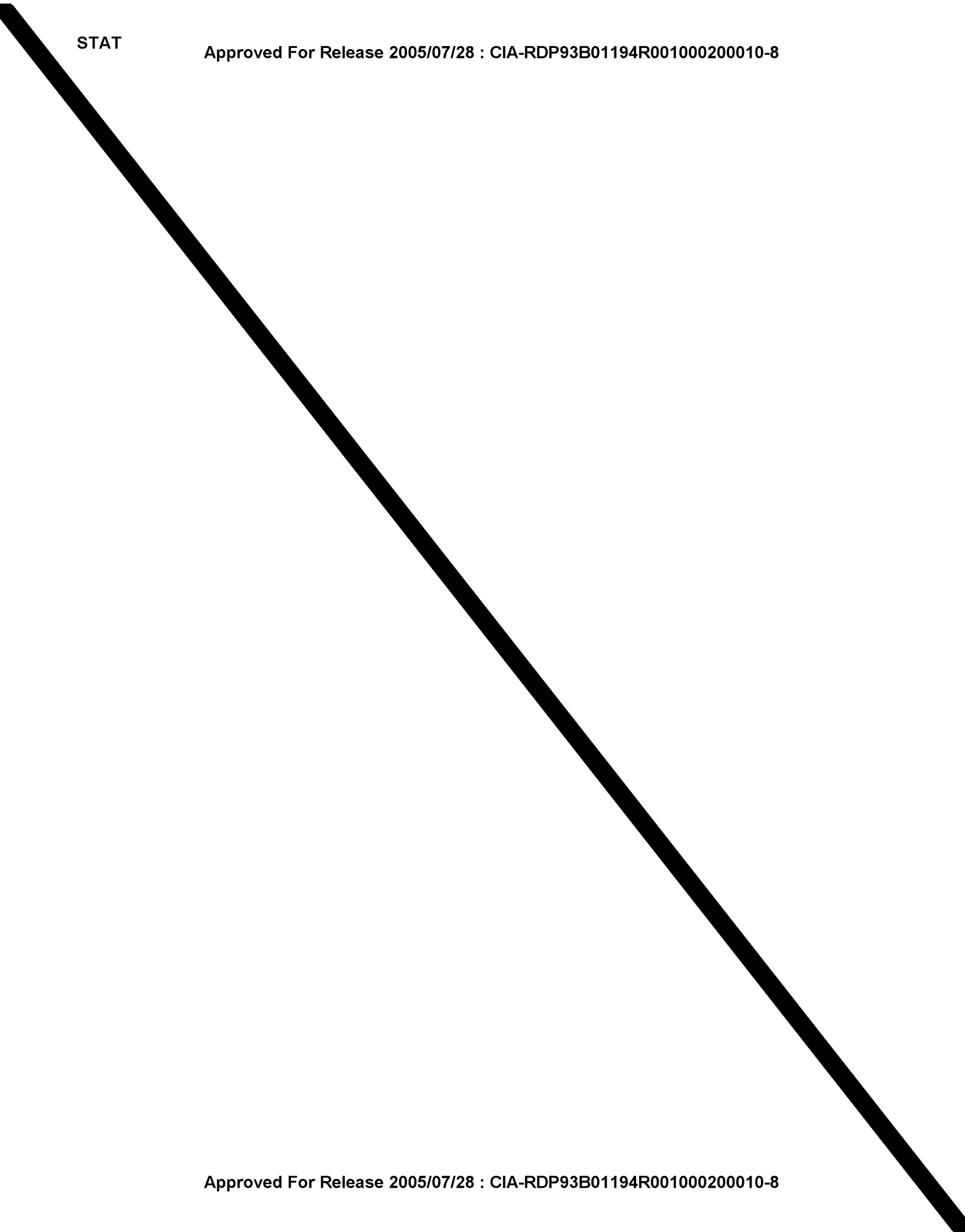
Implications for the Future

The medical record makes a self-evident case for considering Agency personnel, especially those serving abroad, a special case within the general government service. They unmistakeably are asked to accept unusually high risks because of their employment, and they demonstrably fall victim to many of these risks. It is entirely appropriate medically, therefore, that a provision for early

retirement be made available to individuals placed in these circumstances.

The implications of the record extend well beyond this. The risks of service abroad are directly proportional to the age of employees assigned. Notwithstanding the apparent good health of those older employees sent overseas, their age-specific casualty rate is distinctly higher than the average employee--in direct proportion to their age. Sending even the healthiest older employees abroad therefore entails some added risks to both themselves and to the Agency, which must be carefully weighed. For most older individuals, a majority of our posts would be medically out of the question, because of a combination of the employees existing problems and the dearth of medical resources at the post.

Even were the Agency forced to confront a dramatic increase in employees from the ages to 50 to 65, the realities of overseas service would not be changed. Revising the medical criteria for overseas assignment would be a major injustice both to those older employees and to the Agency. Not revising the criteria would overwhelm headquarters with large numbers of individuals unsuitable for most overseas assignments. Either option could only be destructive to the Agency's ability to effectively perform the tasks it has been created to perform.



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